City of Scottsdale
Summary Plan Description

City of Scottsdale PPO Plan through Aetna Open Choice Plan

Effective January 1, 2004

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for the City of Scottsdale PPO Plan
through
Aetna Open Choice Plan

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Welcome!

Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating physicians and hospitals is available to provide you with access to medical care 24 hours a day, 7 days a week.

We believe that through the appropriate use of health resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your Open Choice (PPO) benefits program is self-funded by the City of Scottsdale and administered by an independent organization, Aetna Life Insurance Company (Aetna).

We wish you the best of health.

How to Use Your Summary Plan Description

This booklet is your guide to the benefits available through your employer's Open Choice Preferred Provider Organization (PPO) Plan ("the Plan"). Please read this booklet carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the "Member Services" section later in this book.

Tips for New Plan Participants

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See "In Case of Medical Emergency" for emergency care guidelines.

This plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

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How the Plan Works

Plan participants have access to a network of participating Primary Care Physicians, specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training. Your level of benefits will depend upon whether you use a provider from Aetna's Open Choice network when you seek medical care.

When you use a provider that participates in the Aetna network (participating provider), you receive benefits at the in-network level. You can go to any doctor in the network. The Plan will pay most eligible expenses at the coinsurance percentage stated in the Summary of Benefits after you meet an annual deductible. Once you meet the in-network out-of-pocket maximum, the Plan will pay your in-network expenses at 100%. If you receive care at the in-network level, you generally do not need to submit claim forms. The participating provider, hospital or lab will submit your claims. It is recommended that you check with Aetna member services to confirm that the provider listed in the Aetna directory is still a participating provider.

When you choose to use a health care provider that does not participate in Aetna's network (non-participating provider), you will receive benefits at the out-of-network level. The Plan will pay most eligible expenses at a percentage of reasonable and customary charges after you meet an annual out-of-network deductible. Once you meet the out-of-network out-of-pocket maximum, the Plan will pay your out-of-network expenses at 100% of reasonable and customary charges. You must submit claim forms and arrange for utilization review and required certifications.

Important Plan Provisions

Annual deductible

The annual deductible is the out-of-pocket expense you incur each plan year before Plan benefits begin. Separate deductibles apply to in-network and out-of-network expenses. Only expenses for covered services count toward satisfying your deductible. Expenses above the reasonable and customary limits set by Aetna are not counted. Co-pays do not count towards your deductible.

Family deductible

You and your covered dependents combined will not have to meet more than the family deductible shown in the Summary of Benefits.

Out-of-pocket maximum

The out-of-pocket maximum is the amount of expenses you pay in a plan year before the Plan pays 100% of eligible expenses for the remainder of the year. Separate maximums apply for in-network and out-of-network expenses. Refer to the Summary of Benefits for the maximums. Prescription drug copays, expenses that exceed Aetna guidelines for reasonable and customary charges and non-covered charges do not count toward the out-of-pocket maximum.

Family out-of-pocket maximum

The Plan will pay 100% of eligible expenses for you and your covered dependents for the remainder of the plan year when expenses for you and your covered dependents combined reach the family out-of-pocket maximum. Separate maximums apply for in-network and out-of-network expenses. Refer to the Summary of Benefits for the maximums. Prescription drug copays, expenses that exceed Aetna's guidelines for reasonable and customary charges and non-covered charges do not count towards the out-of-pocket maximum.

Lifetime maximum

The lifetime maximum coverage as shown in the Summary of Benefits is the total amount the Plan will pay for each participant during the person's lifetime. The lifetime maximum includes all expense for in-network and out-of-network expenses.

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to **www.aetna.com/docfind**. Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Your ID Card

When you join the Plan, you will receive ID cards for you and your family (if applicable). Always carry your ID card with you. It identifies you as a Plan participant when you receive services. When you obtain a prescription at a participating pharmacy, remember to present your ID card. If your card is lost or stolen, please notify Aetna immediately.

Summary of Benefits

Below is a brief overview of some of the benefits available under the Plan. Refer to the sections entitled "Your Benefits" and "Exclusions and Limitations" for more detailed information.

All non-emergency hospital services require a prior referral from your physician.

Type of Service or Supply	In network	Out-of-network
Lifetime Maximum	$2,000,000	
Plan Deductible		
Individual	$ 1000	$2000
Family	$ 2000	$4000
Annual Out of Pocket Limit		
Individual	$ 3500	$4500
Family	$ 7000	$9000
Primary and Preventive Care		
PCP Office Visits	90% after deductible	70% after deductible
Routine Examinations	90% after deductible	70% after deductible
Routine Child and Well-Baby Care	90 % after deductible	70% after deductible
Immunizations and allergy injections	90% after deductible	70% after deductible
Routine Gynecological Exams	90% after deductible	70% after deductible
Routine Mammogram	90% after deductible	70% after deductible
Prostate Screening	90% after deductible	70% after deductible
Routine Eye Examination-one exam per 12 month period	$10 copay per visit	No benefit
Eyeglasses/Contact Lenses	Discounts available through Vision One Discount Program	
Routine Hearing Screenings-one exam per 12 month period.	$10 copay per visit.	No benefit
Hearing Aids	Discounts available through Arizona HearCare.	
Specialty and Outpatient Care		
Specialist Office Visits	90% after deductible	70% after deductible
Prenatal Care	90% after deductible	70% after deductible
X-rays and Lab Tests	90 % after deductible	70% after deductible
Therapy (speech, occupational, physical)-maximum 60 visits per calendar year)	90% after deductible	70% after deductible
Chiropractic Care-maximum 20 visits per calendar year	90% after deductible	70% after deductible
Home Health Care-maximum 40 visits per calendar year	90% after deductible	70% after deductible
Hospice Care	90% after deductible	70% after deductible
Durable Medical Equipment (DME)	90% after deductible	70% after deductible
Prosthetic Devices	90% after deductible	70% after deductible

Type of Service or Supply	In-network	Out-of-network
Inpatient Services		
Hospital Room and Board and Other Inpatient Services	90% after deductible	70% after deductible
Skilled Nursing Facilities –maximum 60 days per calendar year	90% after deductible	70% after deductible
Hospice Facility	90% after deductible	70% after deductible
Surgery and Anesthesia		
Inpatient Surgery	90% after deductible	70% after deductible
Outpatient Surgery	90% after deductible	70% after deductible
Mental and Nervous Conditions		
Inpatient Treatment	80% after $150 copay per admission. Copay waived if readmitted within 10 days.	
Outpatient Treatment through Aetna	90% after deductible	70% after deductible
Outpatient Treatment through CIGNA Behavioral Health	No copay; unlimited visits	
Partial Hospitalization	1 day of inpatient care may be exchanged for 2 partial hospitalization sessions in lieu of hospitalization. Must be approved in advance by Aetna.	
Treatment of Alcohol and Drug Abuse		
Inpatient Detoxification	80% after $150 copay per admission. Copay waived if readmitted withing 10 days.	
Inpatient Rehabilitation	80% after $150 copay per admission. Copay waived if readmitted within 10 days	
Outpatient Detoxification through CIGNA Behavioral Health	No copay; unlimited visits.	
Outpatient Detoxification through Aetna	90 % after deductible	70% after deductible
Outpatient Rehabilitation through CIGNA Behavioral Health	No copay; unlimited visits.	
Outpatient Rehabilitation through Aetna	90% after deductible	70% after deductible

Type of Service or Supply	In-network	Out-of-network
Emergency Care		
Emergency Room (copay waived if admitted)	$ 100 copay +10% coinsurance after in-network deductible	
Urgent Care	$50 copay +10% coinsurance after in-network deductible	
Ambulance	90% after deductible	70% after deductible
Prescription Drugs	No annual maximum	
Retail (34-day supply)		
Generic drugs	10% coinsurance ($10 min-$20 max)	
Brand name formulary drugs	20% coinsurance ($20 min-$40 max)	50% coinsurance
Non-formulary drugs	40% coinsurance ($40 min-$80 max)	
Mail Order (90-day supply)		
Generic drugs	$ 20 copay	No benefit
Brand name formulary drugs	$ 50 copay	
Non-formulary drugs	$100 copay	

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is **medically necessary** for the prevention, diagnosis or treatment of your illness or condition. Refer to the "Glossary" section for the definition of "medically necessary."

Certain services must be precertified by Aetna. You or your participating provider is responsible for obtaining this approval.

Primary and Preventive Care

One of the Plan's goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable deductible, copayment or coinsurance)

- Office visits during office hours and during non-office hours.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your physician.
- Well-child care from birth.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital
- Routine gynecological examinations and Pap smears.
- Annual mammography screening for women. **Note**: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Routine immunizations.
- Periodic eye examinations-one per 12 month period.
- Routine hearing screenings-one per 12 month period.
- Injections, including routine allergy desensitization injections.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury-up to 60 visits per calendar year.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.

- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "In Case of Emergency").
- Home health services provided by a participating home health care agency up to 40 visits per calendar year, including:
  - skilled nursing services provided or supervised by an RN.
  - services of a home health aide for skilled care.
  - medical social services provided or supervised by a qualified physician or social worker if your physician certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.

    Note: The Plan does **not** cover the following hospice services:
    - bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
    - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
    - respite care when the patient's family or usual caretaker cannot, or will not, attend to the patient's needs.
- The Plan covers surgery needed to:
  - Treat a fracture, dislocation or wound.
  - Cut out:
    - Teeth partly or completely impacted in the jaw bone;
    - Teeth that will not erupt through the gum;
    - Other teeth that can't be removed without cutting into the bone;
    - The roots of a tooth without removing the entire tooth; or
    - Cysts, tumors or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is covered only when it's done in connection with the removal, replacement or repair of teeth.
  - Change the jaw, jaw joints or bite relationships using a cutting procedure when appliance therapy alone can't improve function.
- Reconstructive breast surgery following a mastectomy, including:
  - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
  - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
  - physical therapy to treat the complications of the mastectomy, including lymphedema.

- Infertility services to diagnose and treat the underlying medical cause of infertility.
    - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
    - evaluation of ovulatory function,
    - ultrasound of ovaries at an appropriate participating radiology facility,
    - postcoital test,
    - hysterosalpingogram,
    - endometrial biopsy, and
    - hysteroscopy
    - Semen analysis at an appropriate participating laboratory is covered for male Plan participants.

- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth).
- Orthoptics
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury. The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion. Replacement, repair and maintenance are covered only if:
    - they are needed due to a change in your physical condition, or
    - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

Inpatient Care In a Hospital, Skilled Nursing Facility or Hospice

If you are confined as an inpatient (with prior referral except in emergencies), you receive the benefits listed below. See "Behavioral Health" for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your physician while confined)
- Confinement in semi-private accommodations in a skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your physician while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood. Fees related to autologous blood donations are covered when billed as part of the hospital's per diem charge.

- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
  - cardiac rehabilitation, and
  - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. To receive in network level of benefits, transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – **after consulting with you** – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

Note: You or your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. When you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Treatment of Mental or Nervous Conditions

The Plan covers the following services for mental health treatment:

- **Inpatient** medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis.

When precertified by Aetna, one day of inpatient treatment may be substituted for four outpatient visits, up to a maximum of 10 inpatient days/40 outpatient visits. One day of inpatient treatment may be substituted for two days of partial hospitalization, if approved by Aetna.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your physician.

Rehabilitation services are **not** covered.

The Plan covers the following services for treatment of alcohol and drug abuse:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent, upon referral by your provider.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your physician.
- **Outpatient** visits to a behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.
- Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Prescription Drugs

The Plan pays, subject to any limitations specified under "Your Benefits," the cost incurred for outpatient prescription drugs that are obtained from an in-network or out-of-network pharmacy. You must present your ID card and make the copayment shown in the "Summary of Benefits" for each prescription at the time the prescription is dispensed.

The Plan covers the costs of prescription drugs, in excess of the copayment, that are:

- Medically necessary for the care and treatment of an illness or injury, as determined by Aetna;
- Prescribed in writing by a physician who is licensed to prescribe federal legend prescription drugs or medicines; and

- Not listed under "Prescription Drug Exclusions and Limitations," below.

Each retail prescription is limited to a maximum 34-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy to receive the in-network level of benefits. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon Aetna's formulary. The formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic drug or a covered brand-name drug that appears on the formulary. Your copayment will be highest if your physician prescribes a covered brand-name drug that does not appear on the formulary.

Mail Order Drugs

Participants in the Plan who must take a drug for more than 30 days may obtain up to a 90-day supply of the drug at a participating mail order pharmacy, if authorized by their physician. The minimum quantity dispensed by a mail order pharmacy is for a 31-day supply, and the maximum quantity is for a 90-day supply. The copayment shown in the "Summary of Benefits" will apply to each mail order purchase.

Step-Therapy Program

Your pharmacy benefits plan includes Aetna's step-therapy program. Step-therapy is a type of precertification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. However, if it is medically necessary for you to use a step-therapy medication as initial therapy without trying a prerequisite therapy drug, your physician can request coverage of the step-therapy medication as a medical exception by contacting the Pharmacy Management Precertification Unit.

The step-therapy program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, "cost information" includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's Formulary.

The drugs requiring step-therapy are subject to change. Please call Member Services or visit Aetna's website for the current Step-Therapy List.

Precertification

Your pharmacy benefits plan includes Aetna's precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be precertified by Aetna's Pharmacy Management Precertification Unit before they will be covered. Only your physician can request precertification for a drug.

The precertification program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's Formulary.

The drugs requiring precertification are subject to change. Call Member Services or visit Aetna's website for the current Precertification List.

Covered Drugs

The Plan covers the following:

- Outpatient prescription drugs when prescribed by a physician who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations and exclusions described in this booklet.
- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:
    - the drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or
    - the safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
    - diabetic needles and syringes.
    - alcohol swabs.
    - test strips for glucose monitoring and/or visual reading.
    - diabetic test agents.
    - lancets (and lancing devices).
    - oral contraceptives.
    - one diaphragm per 365-day period .
    - up to 5 vials of Depo-Provera in a 365 consecutive-day period. A separate copayment applies to each vial.
    - Norplant and IUDs are covered when obtained from your PCP or participating Ob/Gyn.
- Drugs prescribed to aid or enhance lifestyle/performance, including sildenafil citrate, phentolamine, apomorphine and alprostadil in oral and topical (including but not limited to gels, creams, ointments and patches) forms. Coverage is limited to a total of no more than 7 pills or other forms (in unit amounts determined by Aetna to be similar in cost to oral forms) per 34-day supply. Mail order supplies are not covered.

Prescription Drug Exclusions and Limitations

Prescription Drug Exclusions

The following services and supplies are not covered by the Plan, and a medical exception is not available for coverage:

- Any drug that does not, by federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written.
- Any drug that is not medically necessary.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Any prescription for which the actual charge to you is less than the copayment.
- Any prescription for which no charge is made to you.
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital or similar facility.
- Take home prescriptions dispensed from a hospital pharmacy upon discharge from the hospital, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Drugs used for the purpose of weight reduction, including the treatment of obesity.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Drugs labeled "Caution - Limited by Federal Law to Investigational Use" and experimental drugs.
- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- The Plan does not cover:
    - injectable drugs used in the treatment of infertility.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

- A retail or mail order pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- To receive the in-network level of benefits, prescriptions may be filled only at a participating retail or mail order pharmacy, except in the event of emergency or urgent care. Aetna will not reimburse Plan participants for out-of-pocket prescription purchases from either a participating or non-participating pharmacy in non-emergency, non-urgent care situations.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.
- The conversion privilege does not apply to prescription drug coverage.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Biofeedback, except as specifically approved by Aetna.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Charges for a service or supply furnished by a participating provider that exceed the provider's negotiated charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the Plan are paid.
- Charges for services and supplies:
    - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
    - Furnished, paid for, or for which benefits are provided or required under any law of a government. This exclusion will not apply to "no fault" auto insurance if it: a) is required by law; b) is provided on other than a group basis; and c) is included in the definition of "other group plans" in the "Coordination of Benefits" section. In addition, this exclusion will not apply to: a) a plan established by a government for its own employees or their dependents; or b) Medicaid.
- Charges that a covered person is not legally obliged to pay.
- Charges to the extent they are not reasonable charges, as determined by Aetna.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve or alter appearance or self-esteem, whether or not for psychological or emotional reasons. However, the Plan covers the following:
    - reconstructive surgery to correct the results of an injury.
    - surgery to improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as the result of:
        - a congenital defect (such as cleft lip and cleft palate), or
        - disease, or
        - surgery performed to treat a disease or injury.
    - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary.

- Custodial care and rest cures.
- Dental care and treatment, except as described under "Your Benefits."
- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Eyeglasses, vision aids, hearing aids and communication aids.
- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Infertility services, except as described under "Your Benefits." The Plan does not cover:
    - purchase of donor sperm and any charges for the storage of sperm.
    - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
    - cryopreservation and storage of cryopreserved embryos.
    - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
    - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
    - injectable infertility drugs.
    - the costs for home ovulation prediction kits.
    - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
    - services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
- Marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Reversal of voluntary sterilizations, including related follow-up care.
- Services and supplies not medically necessary, as determined by the Plan or its designee, for the diagnosis, care or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist.
- Services of a resident physician or intern rendered in that capacity.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.

- Services or supplies that are considered to be experimental or investigational. Refer to the "Glossary" for a definition of "experimental."
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
  - drugs related to treatments not covered by the Plan, and
  - drugs related to the treatment of infertility except as described under "Prescription Drugs".
- Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (wrinkle method),
  - cytotoxicity testing (Bryan's Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures or treatment of obesity, except where mandated by law.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - vision perception training.
  - carbon dioxide therapy.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis except as described in "Your Benefits".
- Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.

- Treatment of injuries sustained while committing a felony.
- Treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.
- Weight reduction programs and dietary supplements.

In addition to the above exclusions, the Plan does not cover the following services and supplies:

- Routine hand and foot care services, including routine reduction of nails, calluses and corns.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of the Plan or its designee are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

In Case of Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

> An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
>
> - *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
> - *Serious impairment to bodily function; or*
> - *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

- Heart attack or suspected heart attack.
- Poisoning.
- Severe shortness of breath.
- Uncontrolled or severe bleeding.
- Suspected overdose of medication.
- Severe burns.
- High fever (especially in infants).
- Loss of consciousness.

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your physician first, if possible. However, if a delay would be detrimental to your health, seek the nearest emergency facility or dial 911 emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your physician so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. All follow-up care must be coordinated by your physician.
5. If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Coverage for emergency care in the emergency room is shown in the Summary of Benefits.

Urgent Care

Treatment that you obtain for an urgent medical condition is covered if:

- The service is a covered benefit; and
- A delay in receiving care would have caused serious deterioration in your health.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Earaches.
- Sore throat.
- Fever.

Coverage for urgent care conditions is shown in the Summary of Benefits.

Special Programs

Alternative Health Care Programs

Natural Alternatives - If you are interested in alternative therapies such as acupuncture or massage therapy, Aetna has a program to meet your needs. Aetna's Natural Alternatives program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.

Vitamin Advantage™ - You can save on vitamins and nutritional supplements purchased through mail order, over the phone, by fax, or over the Internet.

Natural Products - You also can save on many health-related products, including aromatherapy, foot care and natural body care products.

You may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through these programs.

To Find Out More - Call the Member Services number on your ID card, or visit Aetna on the web at **http://www.aetna.com/products/natural_alt_99.html**. There you can find a listing of participating providers, vendors and the latest additions to the product list. Visit the website often — these programs are growing!

Natural Alternatives is not available in all states.

Fitness Program

Aetna offers Plan participants access to discounted fitness services provided by GlobalFit™. Depending upon your location, you may be eligible for one of two GlobalFit programs.* Under ***GlobalFit A***, Plan participants can join the GlobalFit network and receive discounts on their health club membership rate. Under ***GlobalFit B***, Plan participants can join included clubs directly, receiving the club's lowest corporate rate for the type of membership selected. Both programs offer Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club** to join;
- Guest privileges at other participating GlobalFit health clubs,** and
- Discounts on certain home exercise equipment.

* *For current club members, participation under this program may not be available at all clubs.*
** *Not available at all clubs.*

To determine which program is offered in your area and to view a list of included clubs, visit the GlobalFit website at **www.globalfit.com/fitness**. If you would like to speak with a GlobalFit representative, you can call the GlobalFit Health Club Help Line at 1-800-298-7800.

Healthy Outlook Program® -- Disease Management for the 21st Century

Aetna has four programs aimed at helping members and their physicians to better manage chronic disease.

Asthma Management Program (pediatric and adult)

The Asthma Management program integrates comprehensive asthma education and instruction in the use of asthma management equipment designed for home use.

Heart Failure Management Program

This program enables patients to receive certain intravenous drugs in the convenience of home and provides education to help them improve their lifestyle and reduce the risk of future hospitalizations.

Diabetes Management Program

The Diabetes Management Program combines member education with blood glucose self monitoring to help achieve better blood sugar control and lessen the chance for the complications of diabetes to develop.

Low Back Pain Disease Management Program

This program provides access to educational materials to help prevent flare-ups of low back pain.

Additional information about Aetna's Disease Management Programs can be found on Aetna's website at **http://www.aetna.com/products/extra/healthy_outlook.html.**

Member Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Member Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit **http://www.aetna.com/products/health_education.html**.

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent reminders listing an examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Adult Preventive Reminders

Preventive care recommendations can overlap in some cases for people age 50 and older. Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats for people in this age group.

Vaccination programs against diseases such as influenza and pneumococcal pneumonia have been shown to reduce the incidence of illness and death from these diseases.

Aetna sends annual reminders stressing the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping our members lead longer, healthier lives. Member Health Education provides members with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female members, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, female members are sent information stressing the importance of annual gynecological exams, direct access to care, as well as instructions on how to perform breast self-examination.

Colorectal

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months.* The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

* *Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services. Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Healthy Breathing® Program

Quitting smoking is one of the biggest steps people can take to improve their health. Millions of people successfully quit smoking each year. That's why Aetna offers the Healthy Breathing Program, which provides access to the GlaxoSmithKline's Committed Quitters® service. The program is available to Plan participants. The program is an 8- to 12-week smoking cessation program that uses nicotine replacement therapy and a personal quit plan to help smokers break their addiction to cigarettes.

Eligible Plan participants who call Member Services using the toll-free telephone number on their Aetna ID card can obtain a brochure that contains a $5 coupon redeemable for the purchase of either a Nicorette® (nicotine gum) or NicoDerm®CQ® (nicotine patch) Starter Kit*. These products can help ease the craving for nicotine and improve the chances of quitting successfully. They are available without a doctor's prescription, although you should discuss use of these products with your physician.

Members can call the 1-800 number in the Starter Kit to begin a quit program or register on line at **www.committedquitters.com**. A personal quit plan usually arrives within a week after calling the 1-800 number. Over the following weeks, members are then sent materials that include information on coping strategies and how to use GlaxoSmithKline's Nicorette or NicoDerm CQ safely and effectively.

If you are an eligible Aetna member, you may call the Member Services number on your Aetna ID card to request the Healthy Breathing brochure.

* *Committed Quitters®, Nicorette®, NicoDerm®, and CQ® are registered trademarks owned by and/or licensed to GlaxoSmithKline and are used under license.*

Healthy Eating™ Program

Aetna's *Healthy Eating* booklet provides an easy-to-follow approach to overall better health through good nutrition. The information provides you and your family with tools you can use to develop a healthy eating plan that's realistic. Following a nutritious diet can help you:

- Reduce your risk of illness and disease
- Manage your weight
- Boost your ability to fight illness
- Increase your energy levels
- Look and feel your personal best
- Improve your performance

The *Healthy Eating* booklet outlines the benefits of a healthy diet and how to get started. It's geared toward helping you understand and use the Food Guide Pyramid, read the "Nutrition Facts" labels on most foods, lower the amount of fat you eat, and become more physically active. Sensible weight management is also addressed. The booklet is available to all Plan participants.

Call the Member Services number on your Aetna ID card to request the Healthy Eating booklet.

Healthy Insights Member Newsletter

Aetna periodically publishes the *Healthy Insights* newsletter. The newsletter features health-related information, education about various benefits and issues important to quality management and patient management. *Healthy Insights* is an important resource that communicates with Plan participants about a wide variety of topics.

Informed Health® Line

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.

Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation.

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

Numbers-to-Know™ -- Hypertension and Cholesterol Management

Aetna created *Numbers To Know*™ to promote blood pressure and cholesterol monitoring. The *Numbers To Know* mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

Hypertension and high cholesterol are never "cured" but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay "heart healthy" by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

National Medical Excellence Program®

Aetna's National Medical Excellence Program® helps eligible Plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants.
- National Special Case Program, developed to coordinate arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant's home.
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered.
- As the NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services;
- The lodging expenses you incur for lodging away from home to receive covered outpatient services from a NME Program provider;
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services; and
- Your companion's lodging expenses when their presence is required to enable you to receive services from a NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by **one** companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per episode of care. Lodging expenses are subject to a $50 per night maximum for each person.

Travel and lodging expenses must be approved in advance by Aetna; if you do not receive approval, the expenses are **not** covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest to occur of:

- One year after the day a covered procedure was performed;
- The date you cease to receive any services from the Program provider in connection with the covered procedure; or
- The date your coverage terminates under the Plan.

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies and treatments that are considered necessary for your medical condition. Treatment that is considered experimental (as determined by Aetna) is **not** covered by the Plan. Refer to the *Glossary* for a definition of "experimental."

Vision One® Discount Program

Plan participants are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the Vision One program at thousands of locations nationwide. Just call 1-800-793-8616 for information and the location nearest you.

Plan participants are also eligible to receive a discount off the provider's usual retail charge for Lasik surgery (the laser vision corrective procedure) offered by Cole/LCA-Vision LLC through the national Lasik network of LCA Vision, Inc. Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care. To find the closest surgeons, call 1-800-422-6600 and speak to a Lasik customer service representative.

Vision One is a registered trademark of Cole Vision.

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Breast Cancer Case Management

Aetna's breast cancer case management program assists female Plan participants who have been diagnosed with breast cancer in making informed choices for their care. This special educational and support program includes:

- A dedicated breast cancer nurse case manager to answer your questions about coverage, assist with necessary claims authorizations, and facilitate access to treatment by participating specialists and primary care physicians and at participating facilities.
- Educational materials, including *The Wellness Community Guide to Fighting for Recovery From Cancer*.
- Second opinions at participating facilities.

Case Management and Education for Diabetics Considering Pregnancy

Aetna provides diabetic women considering pregnancy with educational materials and nurse case management to help better manage their blood sugar levels prior to pregnancy, which can decrease the chance of delivering babies with birth defects.

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Moms-to-Babies Maternity Management Program™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Assistance in accessing prenatal care.
- Case management by registered nurses, who will assist in arranging covered services, coordinate covered specialty care, review the program's features and answer general pregnancy-related questions.
- Smoke-free Moms-to-be™, a personalized stop-smoking program designed specifically for pregnant women.
- Focused, educational information, "For Dad or Partner."
- A comprehensive pregnancy handbook.

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and Moms-to-Babies case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, ***Pregnancy Risk Assessment***, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

Eligibility

Who Is Eligible to Join the Plan

You are eligible to enroll in the Plan if you meet the City of Scottsdale's eligibility requirements. Eligibility requirements are the following:

- regular, full time, job share and part time benefited employees of the City of Scottsdale working at least 20 hours per week and members of the City Council
- retired employees and retired members of the City Council who are under age 65 and who draw benefits within 60 days of retirement under the Arizona State Retirement System, the Public Safety Retirement System or the Elected Officials Retirement System and are not eligible for Medicare/Medicaid benefits.

When you join the Plan, your spouse and your dependent children are also eligible to join. A dependent child must be unmarried and under the age of 19. Coverage will continue until the day the child attains age 19. A child may be covered up to the day they attain age 25 if they are a full-time student (taking at least six credit hours) and dependent on the employee for support. Proof of full-time student status is required each year. A dependent child over age 19 who is continuously incapable of self-sustaining employment because of mental or physical handicap, is chiefly dependent upon the employee for support and has become incapacitated before the limiting age may be eligible for coverage. You may enroll your natural child, foster child, stepchild, legally adopted child, child placed for adoption, a child for whom you are the legal guardian or a child for whom you have a Medical Support Order.

You may also cover your "domestic partner" or "domestic partner children" as dependents, in accordance with the rules established by the City of Scottsdale. A domestic partner is an individual of either sex who shares a long-term committed relationship of indefinite duration with a benefit eligible employee. A Domestic Partnership Affidavit must be completed and submitted with at least three (3) items of documentation as evidence of joint responsibility and commitment and that documentation must be pre-dated by twelve (12) months.

No person may be covered as both an employee and a dependent under the Plan, and no person may be covered as a dependent of more than one employee.

If Your Child Is Adopted

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child in writing within 31 days of the placement.

If Your Child Is Handicapped

Unmarried children of any age who are handicapped may also be covered. Your child is handicapped if:

- He or she is not able to earn his or her own living because of a mental or physical disability which started prior to the date he or she reached age 19, (age 25 if attending school) and
- He or she depends chiefly on you for support and maintenance.

You must provide proof of your child's handicap no later than 31 days after the child's coverage would otherwise end. The Plan may require at reasonable intervals thereafter, satisfactory proof of the child's continued incapacity and dependency, including medical examinations at the Plan's expense.

Coverage for a handicapped child ends on the first to occur of the following:

- The child's handicap ceases;
- You fail to provide proof that the handicap continues;
- The child's coverage as a dependent under the Plan ceases for any reason **other than** attainment of the maximum age for dependent coverage.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order requiring a parent to provide health care benefits to one or more children. Coverage under the Plan can be extended to a child who is covered by a QMCSO, if:

- The QMCSO is issued on or after the date your coverage becomes effective; and
- Your child meets the age and student status requirements of an eligible dependent under the Plan; and
- You request coverage for the child within 31 days of the court order.

Coverage will be effective on the date of the court order.

Enrollment

New Employees

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information, including an enrollment form. You must complete the enrollment form and return it to your Human Resources representative within 31 days of the date you become eligible if you wish to participate in the Plan. If you do not return the form within the 31-day period, your employer will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless "a special enrollment situation" occurs.

Open Enrollment

The annual open enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary and to enroll in the Plan if you previously declined coverage. Beginning in 2004, open enrollment will be held each spring, and the elections you make will be in effect for the fiscal year of July 1 through June 30th

Special Enrollment due to Loss of Other Health Coverage

Under certain circumstances, an Eligible Employee or his/her Dependent who did not enroll during the initial enrollment period may enroll before the next open enrollment period. These circumstances warrant "special enrollment." Special enrollment shall be allowed for either of the following:

- The Eligible Employee or the Dependent satisfies all of the following criteria:
    - Was covered under a group health plan or health insurance coverage (this prior coverage does not include continuation coverage required under federal law) at the time the Eligible Employee or Dependent was first eligible to enroll under the Plan;
    - Declined coverage in writing for that reason;
    - Presents to the Employer evidence of a loss of the prior coverage due to a loss of eligibility for that coverage, or evidence of the termination of employer contributions toward that coverage ("loss of eligibility" includes loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; but it does not include a loss due to the failure of the Eligible Employee or Dependent to pay premiums on a timely basis or termination of the prior coverage for cause); and
    - Notifies the Employer in writing within thirty (30) days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.
- The Eligible Employee or Dependent satisfies all of the following criteria:
    - Was covered under benefits available under COBRA;
    - Declined coverage for that reason;
    - Presents to the Employer evidence that the Eligible Employee has exhausted such COBRA coverage and has not lost such coverage due to the failure of the Eligible Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause; and
    - Notifies the Employer in writing within thirty (30) days of the date of the loss of coverage.

Special Enrollment Due to Addition of Dependent

An Eligible Employee's marriage or the birth, adoption, placement for adoption, or legal guardianship of an Eligible Employee's child triggers special enrollment rights.

- **Non-Participating Employees May Also Enroll**. The addition of a new Dependent triggers enrollment rights for an Eligible Employee even if he/she does not participate in the Plan at the time of the event. For example, upon the birth of an Eligible Employee's child, the Eligible Employee (assuming that he/she did not previously enroll), his/her Spouse, and his or her newborn child may all enroll because of the child's birth. The same rule applies to the Eligible Employee's marriage or adoption of a child if the Eligible Employee had not previously enrolled in the Plan.
- **Deadline for Special Enrollment Period**. The Eligible Employee must request special enrollment in the Plan within thirty (30) days of marriage or birth, adoption or placement for adoption of his/her child. If the Employer, or its designee, does not receive the eligible Employee's completed request for enrollment within this deadline, the Eligible Employee and his/her dependents lose special enrollment rights for that event.

Change in Status

Federal regulations generally require that your plan coverage remain in effect throughout the plan year. However, some changes may be allowed during the plan year if the Plan administrator determines that the individual has a qualifying change in status affecting their benefit needs. The change in coverage must be

consistent with the change in status. As a result of a qualified status change, you may add or delete dependents from your coverage but you may not change plans. A qualified change in status is:

- Your marriage, divorce, legal separation or annulment;
- The birth or adoption of a child;
- The death of your spouse or child;
- A change in the number of your dependents;
- A change in employment status for you, your spouse or your dependent; or
- The beginning or end of an unpaid leave of absence taken by you or your spouse.

Whenever you have a qualified change in status, you must report the change by completing a change form, available from your Human Resources representative. The completed change form must be given to your Human Resources representative within 30 days of the event. Otherwise, you must wait until your employer's next open enrollment period.

Effective Date of Coverage

The date on which coverage becomes effective depends upon when enrollment occurs.

- **Enrollment Within Initial Enrollment Period**. The effective date of coverage for Employees who enroll during the initial enrollment period is the first day of the Eligible Employee's first day of employment or change to eligible status with the Employer. The effective date of coverage for Dependents is at the time of the Eligible Employee's enrollment.

  If Dependent status is acquired after the Employee's initial eligibility, the effective date of coverage shall be the date on which the new Dependent becomes eligible for coverage under the Plan, provided the Employee completes a change form and submits it to the Employer within thirty (30) days after the attainment of Dependent status.

- **Enrollment Not Within Initial Enrollment Period**. If an Eligible Employee or Dependent does not enroll within the initial enrollment period, he or she must wait until the next open enrollment period unless a "special enrollment" or "change in status" situation occurs. The effective date of coverage would be the first day of the Coverage Year for which the open enrollment period was held.

- **Special Enrollment**. When enrollment occurs as the result of a special enrollment due to loss of other health coverage as described above, the effective date of coverage is the first day of the month following the receipt and acceptance of the completed enrollment materials by the Employer or its designee. When enrollment occurs as the result of a special enrollment due to addition or adoption of a child as described above, the effective date of coverage is the date of the event.

- **Change in Life Status**.When enrollment occurs as the result of a qualified change in life status, the effective date of the coverage is the date of the life event.

  Note: Newborn children are automatically covered for 31 days after birth. To continue the coverage beyond 31 days, you must apply by submitting a change form to your Human Resources representative within the 31-day period.

The Plan does not have any pre-existing condition limitation provisions.

When Coverage Ends

Termination of Employee Coverage

Your coverage will end on the last day in which the earliest of the following events occur:

- You voluntarily terminate coverage;
- Your employment terminates;
- You are no longer eligible for coverage;
- You do not make the required contributions;
- You become covered under another health care plan offered by your employer; or
- The Plan is discontinued.

Termination of Dependent Coverage

Coverage for your dependents will end on the last day in which the earliest of the following events occur:

- Your coverage ends for any of the reasons listed above;
- You die;
- Your dependent is no longer eligible for coverage;
- Your payment for dependent coverage is not made when due; or
- Dependent coverage is no longer available under the Plan.

Termination of Retiree Coverage

Coverage for retirees will end on the first day of the month in which the earlier of the following events occur.

- The retiree reaches age 65.
- The retiree dies.
- The retiree opts out of such coverage.
- The retiree fails to pay necessary premiums to the Employer within the established payment schedule as communicated directly to the retiree.

Termination for Cause

A Plan participant's coverage may be terminated for cause. "For cause" is defined as:

- **Untenable relationship**: After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with you or a Plan participant of your family. You will be given 31 days advance written notice of the termination of coverage.
- **Failure to make copayments**: You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay. You will be given 31 days advance written notice of the termination of coverage.

- **Refusal to provide COB information**: You or a member of your family refuses to cooperate and provide any facts necessary for Aetna to administer the Plan's COB provision. You will be given 31 days advance written notice of the termination of coverage.
- **Furnishing incorrect or incomplete information**: You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination will be effective immediately.
- **Fraud against the Plan**: This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination will be effective immediately.
- **Misconduct**: You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated.

Any termination for cause is subject to review in accordance with the Plan's grievance process. You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

Family and Medical Leave

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by your employer to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, your employer may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

Military Leave

If your coverage is terminated by reason of military service under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time, and you are reemployed by the Employer within the time allowed by law, you will be immediately eligible to participate in the Plan on the date you return to employment as an Eligible employee.

COBRA Continuation of Coverage

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called "qualifying events") when you would otherwise lose coverage. To do so, you must pay up to 102% of the full regular cost of coverage.

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

You and your covered family members are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct and you had health care coverage through your employer at the time your left employment; or
- You are no longer eligible because your working hours are reduced and you had health care coverage through your employer at the time your hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify your Human Resources representative of the disability before the end of the original 18-month period to receive the extension, and you must pay up to 150% of the full cost of coverage for every month after the 18th month. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

Continuation of Coverage Due to Other Qualifying Events

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare; or
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent have already continued coverage due to the termination of your employment or your loss of eligibility, your dependent may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

Applying for COBRA Continuation

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; and
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage;

whichever happens later.

If you do not make your election within 60 days, you will lose your COBRA continuation rights.

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

- The COBRA continuation period expires.
- You or your family members do not make the required contributions.
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition. Once the pre-existing condition clause of the new plan ceases to apply, your COBRA coverage will cease.
- You or your family members become enrolled in Medicare. (Coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible.)
- Your employer terminates this health plan.

Portability of Coverage

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your employer will give you a certificate confirming your participation in the Plan when your health coverage terminates under the Plan and, if elected, under COBRA. Aetna will assist your employer with the preparation and distribution of the certificates. Certificates can be obtained from your Human Resources representative.

Conversion From Group to Individual Membership

Most Plan participants who terminate employment or cease to be eligible for benefits may convert to individual membership without evidence of good health if their place of residence remains within the Aetna service area. If you have been continuously enrolled in the Plan for three months, you and/or your eligible dependent may apply to Aetna for a conversion policy within 31 days after:

- Termination of employment.
- Loss of group membership.
- Loss of dependent status.
- Termination of any continuation coverage required under federal or state law.

The converted coverage will not provide the same benefits as the your employer PPO Plan. The rate you pay will be the premium charged for individual policies.

For necessary forms and information about the conversion plan, call the toll-free number on your ID card.

Note: Certain benefits cannot be converted.

Claims

Coordination of Benefits

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the Plan.

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the Plan. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- "No-fault" and traditional "fault" auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the Plan will be reduced, Aetna must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
  - The plan that covers the person as a dependent of a working spouse will pay first;
  - Medicare will pay second; and
  - The plan that covers the person as a retired employee will pay third.
- Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.
- When the parents of a dependent child are divorced or separated:
  - If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule, immediately above, applies.
  - If a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
  - If there is no such court decree, the order of benefits will be determined as follows:
    - the plan of the natural parent with whom the child resides,
    - the plan of the stepparent with whom the child resides,
    - the plan of the natural parent with whom the child does not reside, or
    - the plan of the stepparent with whom the child does not reside.

- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

If it is determined that the other plan pays first, the benefits paid under this Plan will be reduced. Aetna will calculate this reduced amount as follows:

- The amount normally reimbursed for covered benefits under this Plan,
  Less
- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

Subrogation

If you or a covered family member receives benefits from this plan as the result of an illness or injury caused by another person, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This means the Plan may recover costs from all sources (including insurance coverage) potentially responsible for making any payment to you or your covered dependent as a result of an injury or illness, including:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers' Compensation coverage;
- No-fault automobile coverage; or;
- Any first party insurance coverage.

What You Need to Know

Here are some important points about the right of subrogation:

The Plan has a lien on any payments you receive.

The Plan automatically has a lien, to the extent of any benefits it has paid, on any payment you've received from a third party, his/her insurer or any other source. The lien is in the amount of benefits paid by Aetna under this Plan for treatment of the illness, injury or condition for which the other person is responsible.

Your cooperation is required.

You may not do anything to interfere or affect the Plan's subrogation rights.

You also must fully cooperate with the Plan's efforts to recover benefits it has paid. This includes providing all information requested by the Claims Administrator or its representatives. As part of this process, Aetna may ask you to complete and submit certain applications or other forms or statements. If you fail to provide this information, it will be considered a breach of contract and may result in the termination of your health benefits or the instigation of legal action against you.

You must notify Aetna.

If a lawsuit or any other claim is filed to recover damages due to injuries sustained by you or a covered family member, you must notify Aetna. This must be done within 30 days of the date the notice of the lawsuit or claim is given to a person, including an attorney.

The Plan is paid first.

The Plan's subrogation rights are a first priority claim against all potentially responsible person(s), and must be paid before any other claim for damages.

The Plan is entitled to full reimbursement.

The Plan is entitled to full reimbursement first from any payments made by any responsible person(s). This reimbursement must be made, even if the payment is not enough to compensate you or your covered family member in part or in whole for damages. The terms of this plan provision apply and the Plan is entitled to full recovery whether or not any liability for payment is admitted by any potentially responsible person(s), and whether or not the settlement or judgment you receive identifies the medical benefits provided by the Plan. The Plan may be reimbursed from ***any and all*** settlements and judgements, even those for pain and suffering or non-economic damages only.

Yhe Plan chooses the court for any legal action.

Any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction the Plan selects. When you receive benefits under this Plan, you agree to this rule and waive whatever rights you have by reason of your present or future place of residence.

The Plan is not responsible for your attorneys' fees.

The Plan is not required to participate in or pay attorney fees to the attorney you hire to pursue your claim for damages.

Interpreting this provision.

If there is any question about the meaning or intent of this plan provision or any of its terms, the Plan will have the sole authority and discretion to resolve all disputes as to how this provision will be interpreted.

Claim Procedures

A claim occurs whenever a Plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in a PPO plan, you do not need to submit a claim for most of your covered in-network healthcare expenses. However, you must submit your claims for out-of-network expenses. The claim must be submitted promptly to Aetna for payment. Send the itemized bill with a claim form for payment with your identification number clearly marked to the address shown on your ID card. Claim forms are available at www.scottsdaleAz.gov/jobs/Benefacts.

Aetna will make a decision on your claim. For **concurrent care** claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if Aetna makes an **adverse benefit determination**.

Adverse benefit determinations are decisions the Plan or its designees make that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
    - it is not included in the list of covered benefits,
    - it is specifically excluded,
    - a Plan limitation has been reached, or
    - it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see "Grievances and Appeals" for more information about appeals.

Type of Claim	Response Time
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment. Other claims - 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow the Plan participant to appeal.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended as described below.

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more information to process your post service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to

provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that the Plan or its designee have made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called grievances. Complaints about adverse benefit determinations are called appeals.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the receipt of the notice. However, appeals of adverse benefit determinations involving urgent care may be made orally.

The Plan provides for two levels of appeal.. If you are dissatisfied with the outcome of your level one appeal and wish to file a level two appeal, your appeal must be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

Type of Claim	Level One Appeal	Level Two Appeal
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.	36 hours Review provided by City of Scottsdale Benefits Coordinating Committee.
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	15 calendar days Review provided by City of Scottsdale Benefits Coordinating Committee.
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances	Treated like an urgent care claim or a pre-service claim depending on the circumstances
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by City of Scottsdale Benefits Coordinating Committee.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

For a level two appeal, the covered person must make his/her request to the City of Scottsdale Benefits Coordinating Committee in writing. The request must be filed within 60 days of the date of receipt of the level one notice of adverse determination. The request must provide additional information and contain a copy of the reviewed denial letter and be filed by mail or hand delivered to:

City of Scottsdale
Benefits Coordinating Committee
Human Resouces Benefits Program

It is the duty of the covered person to provide copies of the denial letter, all supporting bills and medical provider letters relative to medical condition and treatment, stating why the claim should be paid.

The covered person does not need to attend the meeting of the City of Scottsdale Benefits Coordinating Committee. Should the covered person request to attend; they must notify the Benefits Coordinating

Committtee in writing indicating who would attend. Only the covered person and/or one representative may attend. The Benefits Coordinating Committee has the right to impose reasonable time limits on any presentation by the covered person or their representative.

Requests for appeal, which do not comply with this procedure and time limitation, will not be considered.

The decision of the Benefits Coordinating Committee shall be the final decision of the City of Scottsdale. Unless there are special circumstances, the appeals process outlined above must be completed prior to initiating legal action regarding a claim. If a Claimant intends to initiate legal action, he or she must do so within (2) years after receipt of a notification of Adverse Benefit Determination at the second level of appeal. If, due to special circumstances the Claimant was not required to complete the appeals process outlined above, legal action must be brought within two (2) years of the date the Claimant's claim for benefits was submitted to the Plan. Claimants may not bring legal action after the expiration of the two-year period.

Claim Fiduciary

Your employer has complete discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, your employer has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Your employer has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Your employer may not abuse its discretionary authority by acting arbitrarily and capriciously.

Your employer is responsible for making reports and disclosures required by applicable laws and regulations.

Member Services

Member Services Department

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Member Services toll-free number on your ID card to:

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number;
- Notify Aetna about an emergency.

Please call your physician's office directly with questions about appointments, hours of service or medical matters.

Internet Access

You can access Aetna on the internet at **http://www.aetna.com/members/member_services.html** to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Order a new ID card; or
- Contact the Member Services department with questions.

Please be sure to include your ID number and e-mail address.

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via **www.intelihealth.com**.

Aetna Navigator™

Aetna Navigator provides a single location for the health and medical issues that matter most to you.

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth®. Access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetnanavigator.com**.

When you visit the website, you can see some of Aetna Navigator's distinct features:

- A wealth of health information from InteliHealth, a premier provider of online consumer-based health, wellness and disease-specific information.
- Online customer service functions that allow you to order ID cards and send e-mail inquiries to Member Services.
- Interactive "Cool Tools," including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator and a heart and breath odometer. To access "Cool Tools," look under "Health Tools."
- A preventive care planner that includes recommendations for screenings and immunizations.

Plan participants with certain Aetna plans may also create password-protected Web pages that are personalized to their health care interests. They have access to the features listed above as well as other options including:

- A personal "benefits snapshot" and claims summary.
- DocFind-A-Specialist, Aetna's enhanced online provider directory that helps Plan participants select a specialist based on personal needs and preferences.
- An online survey that allows you to receive customized information based on your personal health interests.

Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan's network.
- Obtain primary and preventive care from the providers you chose.
- Obtain covered care from specialists, hospitals and other providers.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your physician or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at **www.aetna.com**. Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments, coinsurance and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Help your doctor make decisions about your health care.
- Tell your physician if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization..
- Call your physician before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments, coinsurance and deductibles required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments, deductibles and coinsurance amounts and what services are covered and what services are not covered.

Patient Self-Determination Act (Advance Directives)

There may be occasions when you are not able to make decisions about your medical care. An Advance Directive can help you and your family members in such a situation.

What Is an Advance Directive?

An Advance Directive is generally a written statement that you complete in advance of serious illness that outlines how you want medical decisions made.

If you can't make treatment decisions, your physician will ask your closest available relative or friend to help you decide what is best for you. But there are times when everyone doesn't agree about what to do. That's why it is helpful if you specify in advance what you want to happen if you can't speak for yourself. There are several kinds of Advance Directives that you can use to say **what** you want and **whom** you want to speak for you. The two most common forms of an Advance Directive are:

- A Living Will; and
- A Durable Power of Attorney for Health Care.

What Is a Living Will?

A Living Will states the kind of medical care you want, **or do not want**, if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living.

The Living Will is a document that is limited to the withholding or withdrawal of life-sustaining procedures and/or treatment in the event of a terminal condition. If you write a living will, give a copy to your physician.

What Is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a document giving authority to make medical decisions regarding your health care to a person that you choose. The Durable Power of Attorney is planned to take effect when you can no longer make your own medical decisions.

A Durable Power of Attorney can be specific to a particular treatment or medical condition, or it can be very broad. If you write a Durable Power of Attorney for Health Care, give a copy to your physician.

Who Decides About My Treatment?

Your physicians will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want — even if the treatment might keep you alive longer.

How Do I Know What I Want?

Your physician must tell you about your medical condition and about what different treatments can do for you. Many treatments have side effects, and your doctor must offer you information about serious problems that medical treatment is likely to cause you. Often, more than one treatment might help you — and people have different ideas about which is best. Your physician can tell you which treatments are available to you, but they can't choose for you. That choice depends on what is important to **you**.

How Does the Person Named in My Advance Directive Know What I Would Want?

Make sure that the person you name knows that you have an Advance Directive and knows where it is located. You might consider the following:

- If you have a Durable Power of Attorney, give a copy of the original to your "agent" or "proxy." Your agent or proxy is the person you choose to make your medical decisions when you are no longer able.
- Ask your physician to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet that states that you have an Advance Directive and where it is located, and who your agent or proxy is, if you have named one.

Who Can Fill Out the Living Will or Advance Directive Form?

If you are 18 years or older and of sound mind, you can fill out this form. You do not need a lawyer to fill it out.

Whom Can I Name to Make Medical Treatment Decisions When I'm Unable to Do So?

You can choose an adult relative or friend you trust to be your agent or proxy, and to speak for you when you're too sick to make your own decisions.

There are a variety of living will forms available, or you can write your wishes on a piece of paper. If necessary, your doctor and family can use what you write to help make decisions about your treatment.

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

Will I Be Treated If I Don't Execute an Advance Directive?

Absolutely. We just want you to know that if you become too ill to make decisions, someone else will have to make them for you. With an Advance Directive, you can instruct others about your wishes before becoming unable to do so.

Can I Change My Mind After Writing an Advance Directive?

Yes. You may change your mind or cancel these documents at any time as long as you are competent and can communicate your wishes to your physician, your family and others who may need to know.

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your physician, family, friends, and other trusted, interested people.

You are not required to execute an Advance Directive. **If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records.**

How Can I Get More Information About Advance Directives?

Call the Member Services toll-free number on your ID card. Or, you can call Partnership for Caring at Choice in Dying, a community organization, at 1-800-989-9455.

Federal Notices

This section describes laws and plan provisions that apply to reproductive and women's health issues.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the follow procedures for a person receiving benefits for an **appropriate** mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services at the number shown on your ID card.

Plan Information

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse and/or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

General Information About the Plan

Employer/Plan Sponsor	City of Scottsdale Human Resources 7575 E. Main Street Scottsdale, AZ 85251 (480) 312-7600
Employer Identification Number	86-6000735
Plan Name	City of Scottdale Open Choice PPO Plan
Plan Year	The Plan Year runs from January 1-2004-June 30, 2005; each July 1-June 30 thereafter
Plan Administrator	City of Scottsdale Human Resources 7575 E. Main Street Scottsdale, AZ 85251 (480) 312-7600
Type of Administration	The Plan is administered under a contract with Aetna Life Insurance Company.
Source of Contributions to the Plan	employer and employee contributions
Agent for Service of Legal Process	City of Scottsdale

Amendment or Termination of the Plan

Your employer has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description provides complete plan information for the PPO Plan administered by Aetna Life Insurance Company, effective January 1, 2004. The plan description has been designed to provide a clear and understandable description of the Plan and serves as the Summary Plan Description (SPD).

Glossary

A

Allowable Expense(s)
Any medically necessary health care service or expense, part or all of which is covered in full or in part under any of the plans covering the Plan participant for whom the claim is made. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

Appeals
A process used by a Plan participant to request the health plan re-consider a previous authorization or claim decision.

Authorization: See Pre-Authorization/Pre-Certification

B

Benefit
Payment received for covered services under the terms of the Plan.

Benefit Period
The maximum length of time for which benefits will be paid.

Brand Name Drug
A prescription drug that is protected by trademark registration.

C

Case Management
A process of identifying individuals at high risk for problems associated with complex health care needs and assessing opportunities to coordinate care to optimize the outcome.

Certification: See Pre-Authorization/Pre-Certification

Chemotherapy
Treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic Care
An alternative medicine therapy in which the spine and joints are adjusted to treat pain and improve general health.

Claim
A request for payment of benefits for health care services provided to a Plan participant.

Coinsurance The sharing of certain covered expenses by the Plan and the Plan participant. For example, if the Plan covers an expense at 80% (the Plan's coinsurance), your coinsurance share is 20%.

Companion
A person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

Contract
A legal agreement between the City of Scottsdale and Aetna Life Insurance Company that describes administrative responsibilities, benefits, and limitations of the coverage.

Conversion
An option to purchase individual coverage by a person who is terminating coverage under this Plan.

Coordination of Benefits (COB)
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their benefits and provides the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment
The specified dollar amount or percentage required to be paid to a participating provider by, or on behalf of, a Plan participant in connection with benefits.

Covered Benefits or Covered Services
Those medically necessary services and supplies which are covered in whole or in part under the Plan, subject to all the terms and conditions of the agreement between your employer and Aetna Life Insurance Company.

Custodial Care
Any type of care where the primary purpose of the type of care provided is to attend to the Plan participant's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the Plan participant, and general maintenance care of colostomy or ileostomy.

D

Deductible - means the amount of covered expenses that a Plan participant must pay each plan year before the Plan begins paying benefits. There are separate deductibles for in-network and out-of-network expenses.

Diagnostic Tests
Tests and procedures ordered by a provider to determine if a patient has a specific condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include, but are not limited to, radiology, ultrasound, nuclear medicine, and laboratory and pathology services or tests.

Direct Access
Under the Plan, the Plan participant may have "direct access" (sometimes referred to as "open access") to any participating provider **of a specified specialty** without a referral.

DocFind®
Aetna's electronic provider directory (updated weekly) on the Aetna website. You can research participating physicians, hospitals, dentists, pharmacists and other providers in your area through DocFind.

Durable Medical Equipment (DME)
Equipment that is:

- Made for and mainly used in the treatment of a disease or injury;
- Made to withstand prolonged use;
- Suited for use while not confined as an inpatient in the hospital;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Drug Formulary
A listing of prescription drugs and insulin established by Aetna that includes both brand name prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by Aetna. Drugs listed on the formulary are covered under the prescription drug plan, with copayments as shown in the "Summary of Benefits." Also called "formulary**."**

E

Effective Date
The date on which the coverage under a Plan participant's plan goes into effect at 12:01a.m.

Emergency (also called medical emergency.)
An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Experimental
A drug, device, procedure or treatment will be determined to be experimental by the Plan or its designee if:

- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol or protocol (s) used by the treating facility or the protocol or protocol (s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of a Plan participant's particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of a Plan participant's particular condition; or
- It is provided or performed in special settings for research purposes.

Explanation of Benefits
An Explanation of Benefits form is provided to Plan participants to explain how the payment amount for a health benefit claim was calculated. Among other things, the Explanation of Benefits may explain the claims appeal process.

F

Formulary: See Drug Formulary

G

Generic Drug
A prescription drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

H

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA is a federal law enacted in 1996. It was designated to improve availability and portability of health coverage by:

- Limiting exclusions for pre-existing conditions;
- Providing credit for prior health coverage;
- Allowing transmittal of the coverage information (i.e., covered family members and coverage period) to a new insurer;
- Providing new rights to allow individuals to enroll for health coverage when they lose their health coverage or have a new dependent;
- Prohibiting discrimination in enrollment/premiums
- Guaranteeing availability of health insurance coverage for small employers.

HIPAA's Administrative Simplification and Privacy (AS&P) Act final rules took effect in April, 2001. The purpose of these rules is to improve the efficiency of the health care system by standardizing the electronic exchange of health information and protecting the security and privacy of Plan participant-identifiable health information.

Home Health Care
Skilled nursing and other therapeutic services provided by a home health care agency in a home setting as an alternative to confinement in a hospital or skilled nursing facility.

Hospice Care
This is palliative and supportive care, either on an inpatient or outpatient basis, given to a terminally ill person and to his or her family. The focus of hospice programs is to enable terminally ill patients to remain, for as long as they can, in the familiar surroundings of their home.

Hospital
An institution rendering inpatient and outpatient services, accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation, or specialty institution.

I

ID Card
Your Aetna ID card provides proof of your Aetna coverage. An ID card is sent to you after your enrollment is processed and accepted. Your Aetna ID card includes your Plan participant identification number, as well as the toll-free phone number to contact Aetna Member Services. If you need to request a new ID card, you may do so through Member Services.

Infertility
For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.

For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

Infusion Therapy
Treatment accomplished by placing therapeutic agents into the vein, including intravenous feeding. Such therapy also includes enteral nutrition, which is the delivery of nutrients into the gastrointestinal tract by tube.

In-Network
Refers to services received from participating providers.

Inpatient Care
Service provided after the patient is admitted to the hospital, skilled nursing facility or hospice. Inpatient care lasts 24 hours or more.

InteliHealth®
Intelihealth is Aetna's online health information site offered in association with the Harvard Medical School. It is a provider of online consumer-based health, wellness and disease specific information. You can link to Intelihealth from Aetna's website (**www.aetna.com**).

L

Lifetime Maximum
The total amount, as shown in the Summary of Benefits, the Plan will pay for each participant during that person's lifetime. The lifetime maximum includes all expense paid for in-network and out-of-network coverage except for prescription drugs or amounts paid by CIGNA Behavioral Health for outpatient mental health or substance abuse treatment.

M

Medical Emergency: See Emergency.

Medically Necessary: **See Necessary**

Member Services
The Aetna Member Services department assists Plan participants with questions about plan benefits and exclusions and, if applicable to your plan. Calling the toll-free number on your ID card will connect you with your plan's Aetna Member Services office. If you do not have your ID card yet, contact your employer's benefits office for the Member Services toll-free number.

Mental Disorder
A dysfunctional manifestation in the individual that may be physical, psychological or behavioral, and for which treatment is generally provided under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker.

N

Necessary, Medically Necessary, Medically Necessary Services, or Medical Necessity
Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, the Plan or its designee will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to the Plan or its designee's attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;

- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis; or
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting.

Network
Physicians, hospitals and other health care providers who contract with Aetna to participate in health benefits plans.

Non-Participating Provider
This term generally used to mean providers who have not contracted with a health plan to provide services at negotiated fees. Also called "non-preferred care provider."

O

Occupational Therapy
Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, and bathing.

Out-of-Network
The use of health care providers who have not contracted with Aetna to provide services.

Out-of-Pocket Maximum
The maximum out of pocket amount that a Plan participant will have to pay for expenses covered under the Plan. The out of pocket maximum is the sum of copayment, coinsurance and deductible amounts except as noted below. Once the Plan participant reaches the out of pocket maximum(s), the Plan pays 100% of expenses for covered services for the remainder of the plan year. There are separate out-of-pocket maximums for in-network and out-of-network expenses. Certain expenses do not apply toward the out-of-pocket maximum:

- Expenses that exceed reasonable and customary limits.
- Charges for services that are not covered by the Plan.
- Copayments for prescription drugs.

Outpatient: See Outpatient Care

Outpatient Care
Care provided in a clinic, emergency room, hospital or non-hospital surgical facility ("surgicenter") without admission to the hospital or facility.

Outpatient Surgery
Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center, or physician office.

P

Partial Day Treatment
A program offered by appropriately-licensed psychiatric facilities that includes either a day or evening treatment program for mental health or substance abuse. Such care is an alternative to inpatient treatment.

Participating Provider
Any physician, hospital, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services which contracts to provide covered services to Plan participants for a negotiated charge. Also called "preferred care provider."

Physical Therapy
Treatment involving physical movement to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb.

Plan
The self-funded PPO product offered by the City of Scottsdale that represents a set of covered services or expenses accessible through a provider network, if applicable, or direct access to licensed providers and facilities.

Plan Participant
A subscriber or dependent who is enrolled in and covered by a health care plan. Also called **"**enrollee**."**

Plan Year
Plan year is the twelve-month period from July 1 through June 30. For the transition period of January 1, 2004 through June 30, 2005, plan year means the eighteen-month period from January 1, 2004 through June 30, 2005.

Preauthorization / Precertification Also known as "authorization," "certification," or "prior authorization")
Certain healthcare services, such as hospitalization or outpatient surgery, require precertification by Aetna to ensure coverage for those services. When a Plan participant is to receive services requiring precertification through a participating provider, this provider should obtain the necessary precertification for those services prior to treatment. If not using a participating provider, you are responsible for obtatining the necessary precertication.

Preferred Care Provider: See Participating Provider

Prescription
An order of a licensed prescriber for a prescription drug. If it is an oral order, it must promptly be put in writing by the pharmacy.

Prior Authorization: See Pre-Authorization

Prosthetic Devices
A device which replaces all or a portion of a part of the human body. These devices are necessary because a part of the body is permanently damaged, is absent, or is malfunctioning.

Provider
A licensed health care facility, program, agency, physician, or health professional that delivers health care services.

Provider Network: See Network

R

Radiation Therapy
Treatment of a disease by x-ray, radium, cobalt, or high energy particle sources.

Respiratory Therapy
Treatment of illness or disease that is accomplished by introducing dry or moist gases into the lungs.

S

Second Opinion
The voluntary option or mandatory requirement to visit another physician or surgeon for an opinion regarding a diagnosis, course of treatment or having specific types of elective surgery performed.

Skilled Nursing Facility (SNF)
An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the health plan to meet the reasonable standards applied by any of the aforesaid authorities.

Speech Therapy
Treatment for the correction of a speech impairment which resulted from birth, or from disease, injury, or prior medical treatment.

Subscriber
The employee covered under the employer's group agreement. The subscriber can enroll eligible dependents as defined under "Eligibility."

Specialist
A physician who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

T

Terminal Illness
An illness of a Plan participant, which has been diagnosed by a physician and for which the patient has a prognosis of six (6) months or less to live.

U

Urgent Care
Services received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. An urgent medical condition requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever.

W

Well Baby/Well Child Care
Refers to routine care, testing, checkups and immunizations for a generally healthy child from birth through the age of eight.

Wellness Program
A health management program that incorporates the components of disease prevention, medical self-care, and health promotion. It utilizes proven health behavior techniques that focus on preventing illness and disability which respond positively to lifestyle related interventions.

ATTACHMENT A

PRIVACY OF PROTECTED HEALTH INFORMATION

1. **Definitions.** The terms used in this *Privacy of Protected Health Information* attachment shall have the definitions ascribed in HIPAA and its implementing regulations.

2. **Employer's (Plan Sponsor's) Certification of Compliance.** Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) unless the Employer (plan sponsor) certifies that the Plan documents have been amended to incorporate this *Privacy of Protected Health Information* attachment and agrees to abide by this *Privacy of Protected Health Information* attachment.

3. **Purpose of Disclosure to Employer (Plan Sponsor).**

(a) The Plan and any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) only to permit the Employer (plan sponsor) to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Employer (plan sponsor) of Members' protected health information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this *Privacy of Protected Health Information* attachment.

(b) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to Subscribers.

(c) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (plan sponsor).

4. **Restrictions on Employer's (Plan Sponsor's) Use and Disclosure of Protected Health Information.**

(a) The Employer (plan sponsor) will neither use nor further disclose Members' protected health information, except as permitted or required by the Plan documents, as amended, or required by law.

(b) The Employer (plan sponsor) will ensure that any agent, including any subcontractor, to whom it provides Members' protected health information agrees to the restrictions and conditions of the Plan documents, including this *Privacy of Protected Health Information* attachment, with respect to Members' protected health information.

(c) The Employer (plan sponsor) will not use or disclose Members' protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (plan sponsor).

(d) The Employer (plan sponsor) will report to the Plan any use or disclosure of Members' protected health information that is inconsistent with the uses and disclosures allowed under this *Privacy of Protected Health Information* attachment promptly upon learning of such inconsistent use or disclosure.

(e) The Employer (plan sponsor) will make protected health information available to the Member who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

(f) The Employer (plan sponsor) will make Members' protected health information available for amendment, and will on notice amend Members' protected health information, in accordance with 45 Code of Federal Regulations § 164.526.

(g) The Employer (plan sponsor) will track disclosures it may make of Members' protected health information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

(h) The Employer (plan sponsor) will make its internal practices, books, and records, relating to its use and disclosure of Members' protected health information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

(i) The Employer (plan sponsor) will, if feasible, return or destroy all Member protected health information, in whatever form or medium (including in any electronic medium under the Employer's (plan sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the protected health information, when the Members' protected health information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member protected health information, the Employer (plan sponsor) will limit the use or disclosure of any Member protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

5. <u>Adequate Separation Between the Employer (Plan Sponsor) and the Plan</u>.

(a) The following employees or classes of employees or other workforce members under the control of the Employer (plan sponsor) may be given access to Members' protected health information received from the Plan or a health insurance issuer or business associate servicing the Plan:

<u>Senior Benefit Analyst and staff of the City of Scottsdale designated by the Senior Benefit Analyst</u>

(b) The employees, classes of employees or other workforce members identified above will have access to Members' protected health information only to perform the plan administration functions that the Employer (plan sponsor) provides for the Plan.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (plan sponsor), for any use or disclosure of Members' protected health information in breach or violation of or noncompliance with the provisions of this *Privacy of Protected Health Information* attachment. The Employer (plan sponsor) will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of this *Privacy of Protected Health Information* attachment, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose protected health information may have been compromised by the breach, violation or noncompliance.